



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

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| Requestor Name and Address: SUGAR LAND SURGICAL HOSPITAL 1211 HIGHWAY 6 STE 70 SUGARLAND TX 77478 | MFDR Tracking #: M4-10-3698-01 DWC Claim #: Injured Employee: |
| Respondent Name and Box #: FIRST LIBERTY INSURANCE CORP Box #: 01 | Date of Injury: Employer Name: Insurance Carrier #: |

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Request increased reimb"

Amount in Dispute: \$2,492.20

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 29824 was denied as documentation does not support level of service billed. The operative report page 2, paragraph 2 states "We then used an Opus to burn the soft tissue below the clavicle. Then, we smoothed the clavicle even with the undersurface of the acromion." This statement does not support excision of the distal clavicle, which per the American Academy of Orthopaedic Surgeons, April 2004 Bulletin states, "It also is appropriate to code separately for excision of the distal clavicle, if this is done in either an open or arthroscopic procedure. This mean excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint. The code for open procedure is 23120; use 29824 for an arthroscopic procedure." CPT 64416 was denied as procedure code not separately payable under Medicare and or Fee Schedule guidelines. Per Medicare Correct Coding guidelines, CPT 64416 is global/incidental to CPT 29826 and should not be separately billed. The CPT definition of 64416 is injection, anesthetic agent; brachial plexus, continous infusion by catheter (including catheter placement). The operative report, page 2, paragraph 3 states "She did NOT have in my opinion enough redness of the capsule to warrant an intra-articular injection of steroids." This statement indicates no injection was performed and especially not a continuous infusion per the definition of CPT 64416. The procedure was not documented as performed and is not payable."

PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|--------------------|--------------------------|--------------|-------------------|---------------|
| 01/06/2010 | CPT Code 29824 and 64416 | N/A | \$2,492.20 | \$0.00 |
| | | | Total Due: | \$0.00 |

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on April 20, 2010.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - 150 – X901 – Documentation does not support level of service billed.
 - 150 – X652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
 - 42 – U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that “Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;”
3. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was NOT requested by the requestor.
6. CPT Code 29824 was denied using denial codes “150 – X901 – Documentation does not support level of service billed” and “150 – X652 – Recommendation of payment has been based on a procedure code which bests describes services rendered.” According to the American Academy of Orthopaedic Surgeons, April 2004 Bulletin, “It also is appropriate to code separately for excision of the distal clavicle, if this is done in either an open or arthroscopic procedure. This means excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint. The code for the open procedure is 23120; use 29824 for an arthroscopic procedure.” The operative report does not support the level of service billed. Reimbursement is not recommended.
7. CPT Code 64416 was denied using denial code “42 – U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines. According to Medicare CCI edits this code is excluded by both CPT Code 29824 and 29826. A modifier is allowed; however a modifier was not attached to the code. Therefore, reimbursement is not recommended.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031©, the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

March 14, 2011

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.